No. 91-1833

In The

Supreme Court of the United States

October Term, 1992

EVERETT R. RHOADES, M.D., DIRECTOR OF THE INDIAN HEALTH SERVICE, *et al.*,

Petitioners,

vs.

GROVER VIGIL, *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

BRIEF *AMICI CURIAE* NATIONAL CONGRESS OF AMERICAN INDIANS, NATIONAL INDIAN COUNCIL ON AGING, NORTHWEST AREA INDIAN CHILD WELFARE ASSOCIATION IN SUPPORT OF RESPONDENTS

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Pursuant to Rule 36.2 of the Rules of the Supreme Court of the United States, the National Congress of American Indians, 900 Pennsylvania Ave., S.E., Washington, DC 20003; the Northwest Area Indian Child Welfare Association, c/o Regional Research Institute, P.O. Box 751, Portland, OR 97207; and the National Indian Council on Aging, 6400 Uptown Blvd., N.E., City Center 510W, Albuquerque, NM 87110 file the attached brief *amici curiae* in support of Respondents to the above-captioned case. Both parties have consented in writing to the filing of this brief; said letters of consent accompany this brief, as required by Rule 36.

INTEREST OF *AMICI CURIAE*

The National Congress of American Indians is dedicated to protecting the rights and improving the welfare of American Indians and Alaska Natives, to enlightening the public toward a better understanding of Indian people, and to preserving rights under Indian treaties or agreements with the United States. NCAI is the oldest and largest national organization of Indian governments and individuals in the United States. NCAI routinely files briefs *amicus curiae* in Supreme Court cases.

The National Indian Council on Aging, a non-profit organization, is the Nation's foremost advocate for Indian elders, dedicated to improvement of the lives of America's 200,000 American Indians and Alaska Native elders, and preservation of the federal trust duty owed to them.

The Northwest Indian Child Welfare Association, Inc. is an organization, the primary goals of which are to provide tribal social service professionals with training and information that can enhance their practice; to facilitate community prevention efforts in tribal communities centered around protecting and nurturing Indian children; and to increase access to a broad range of services for Indian children and families.

Amici Curiae have two general concerns about the impact of *Rhoades v. Vigil*. First, there is the potential for the future arbitrary termination of services to some of the Indian community's neediest children. With the current federal response to the needs of Indian children and families being woefully inadequate, a court decision with the potential to exclude more Indian children from desperately needed services is unconscionable. The second concern focuses on the impact of the overall trust responsibility that the United States government has to Indian people. This trust responsibility has been well defined in treaty, law, and federal administrative policy. The Indian Health Service's decision to discontinue services to these handicapped children could abrogate this trust responsibility and, if upheld, could set a dangerous precedent for future efforts to enforce the trust responsibility.

SUMMARY OF ARGUMENT

The Supreme Court has ruled in several instances that the United States' trust relationship imposes a duty of fairness on the government's dealings with Indian people. Respondents in this case contend, and the Tenth Circuit has ruled, that a duty of fairness requires the United States to consult with them before terminating the Indian Childrens Program (ICP), a program benefitting severely mentally, physically and emotionally handicapped Indian children. The government disagrees, on the grounds that, first, the federal trust duty extends only to matters involving Indian property and, second, that Congress has never passed a statute expressly creating the ICP and, thus, Respondents do not have a legitimate expectation to be consulted.

Amici believe the government is wrong on both of these points. First, through numerous decisions of the Court *and* congressional enactments it is clear that both the United States and Indian people understand the trust duty – and hence the duty of fairness – extends beyond

matters involving only property. Second, there is an unambiguous history, spanning nearly two centuries, evincing a self-imposed trust duty on the government to deliver health care to Indian people. These factors combine to produce a legitimate expectation in Respondents to be consulted in the ultimate decision by the government whether to terminate the ICP.

ARGUMENT

I. THE UNITED STATES BEARS A TRUST RESPONSIBILITY TO PROVIDE HEALTH CARE TO INDIAN PEOPLE WHICH DERIVES FROM TWO CENTURIES OF THE UNITED STATES' SELF-IMPOSED OBLIGATION

A. The United States Has a Distinct Obligation, Growing Out of Two Centuries of History, to Deal Fairly With Indian People in the Delivery of Health Care Services.

Generally speaking, the federal trust responsibility doctrine has been developed by the Supreme Court and lower federal courts over the past one hundred and seventy years to explain the unique status of Indian tribes and their members and their unique relationship to the United States government.[1] The doctrine is intended to protect Indians whose lives are inextricably intertwined with – and thus dependent upon – the federal government, as is the situation in the case presently before the Court.

The earliest judicial pronouncements of the trust relationship between Indian tribes and the United States came in the 1823 and 1831 decisions of *Johnson v.*

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[1] Chambers, Reid Payton, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 Stanford Law Review 1213, 1215-1234 (1975); Cohen, *Handbook of Federal Indian Law* (Michie Bobbs-Merrill 2d ed. 1982) at 220.

M'Intosh, 21 U.S. (8 Wheat.) 543 (1823), and *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1 (1831), now cornerstones of federal Indian law.[2] In those cases Chief Justice John Marshall described the status of Indian tribes as "domestic dependent nations",[3] an intermediate governmental status more sovereign than states, but less sovereign than foreign nations. Chief Justice Marshall explained the tribes' relationship to the federal government as being "that of a ward to his guardian."[4] The guardian-ward, or trust, relationship between the United States and Indian tribes and tribal members has remained at the core of federal Indian law.[5]

In the seminal decision *Morton v. Ruiz*, 415 U.S. 174, 236-7 (1974), this Court reiterated the "distinctive obligation of trust incumbent upon the Government in its dealings with these dependent and sometimes exploited people," (quoting *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942)), and found that this distinct obligation of trust compelled an "overriding duty of our Federal Government to deal fairly with Indians. . . . " (quoting *Seminole Nation* and *Board of County Commissioners v. Seber*, 318 U.S. 705 (1943)). The Court in *Seminole Nation* had previously described the trust duty as "humane and self-imposed"; that by virtue of "many acts of Congress and numerous decisions of this Court," the United States has "charged itself with moral obligations

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[2] Chambers, *id.*; Cohen at 221.

[3] Cherokee Nation v. Georgia, *supra*, 30 U.S. (5 Pet.) at 16-17.

[4] *Id.*

[5] United States v. Kagama, 118 U.S. 375 (1886); United States v. Candaleria, 271 U.S. 432 (1926); United States v. Creek Nation, 295 U.S. 103 (1935); Seminole Nation v. United States, 316 U.S. 286 (1942); Squire v. Capoeman, 351 U.S. 1 (1956).

of the highest responsibility and trust." *Seminole Nation v. United States, supra*, 316 U.S. at 296-297.[6]

The unique relationship between the United States and Indian people is repeatedly acknowledged by Congress as extending to all areas of Indian life. For example, in enacting the Indian Self-Determination and Education Assistance Act Amendments of 1988, slightly revising previous language, "Congress declare[d] its commitment to the maintenance of the Federal government's unique and continuing relationship with, and responsibility to, individual Indian tribes and the Indian people as a whole through the establishment of a meaningful Indian self-determination policy."[7] The direct trust responsibility the federal government has assumed for the welfare of Indian children, in particular, is clearly demonstrated by the Indian Child Welfare Act of 1978.[8] The congressional findings which accompany the Act make specific mention of the United States' position as Indian childrens' trustee:

> Recognizing the special relationship between the United States and the Indian tribes and the Federal responsibility to Indian people, Congress finds –

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[6] The Court's 1886 decision in *Kagama* goes to the very essence of the reason for describing the trust duty as humane and self-imposed: "These Indian tribes are the wards of the nation. They are communities dependent on the United States; dependent largely for their daily food; dependent for their political rights. . . . *From their very weakness and helplessness, so largely due to the course of dealing of the Federal Government with them and the treaties in which it has been promised, there arises the duty of protection, and with it the power.* This has always been recognized by the Executive and by Congress, and by this court whenever the question has arisen." United States v. Kagama, 118 U.S. 375, 383-385 (1886) (emphasis added).

[7] 25 U.S.C. § 450a(b); *see also* the Johnson O'Malley Act, *infra*, at 25.

[8] 25 U.S.C. §§ 1901-1952.

* * *

> (2) that Congress, through statutes, treaties, and the general course of dealing with Indian tribes, has assumed the responsibility for the protection and preservation of Indian tribes and their resources.
>
> (3) that there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and that the *United States has a direct interest, as trustee, in protecting Indian children* who are members of or are eligible for membership in an Indian tribe.[9]

The interest of the federal government and Indian tribes in protecting Indian people and particularly Indian children is clearly independent of any connection to trust land, and extends beyond reservation boundaries. *See Mississippi Band of Choctaw Indians* v. *Holyfield*, 490 U.S. 30 (1989); *Morton* v. *Ruiz*, *supra*.

In *Morton* v. *Mancari*, 417 U.S. 535 (1974), this Court relied upon "unique legal status of Indian tribes under federal law and upon the plenary power of Congress, based on a history of treaties and the assumption of a 'guardian-ward' status, to legislate on behalf of federally recognized tribes" and upheld Indian preference in Bureau of Indian Affairs hiring and job promotion.[10] Again, the special relationship between the federal government and Indian people extends to individual Indian interests, and is not limited to protection of their natural resources.

The present dispute, like that in *Ruiz*, involves a benefit program created by the United States solely for Indian people. And, just as in *Ruiz*, this dispute raises the issue of whether the government treats Indian people fairly in the administration of the program and in the distribution of the

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[9] 25 U.S.C. § 1901 (emphasis added).

[10] Morton v. Mancari, *supra*, 417 U.S. at 551.

benefits therefrom. From this perspective, the lessons of *Kagama*, *Seminole Nation*, *Seber*, *Mancari* and *Ruiz* teach us that the same distinctive obligation to deal fairly with Respondents, a class of severely emotionally and physically handicapped Indian children, attaches to the conduct of the government in this case. *Dealing fairly* with the Indian children here means, simply, to provide the affected families with *meaningful* access to the administrative process by way of *Federal Register* notice and comment prior to making a decision on the disposition of the Indian Childrens Program.

B. The Government's Characterization of the Trust Responsibility As Extending Only to Indian Property Ignores the Full History and Evolution of the Obligation, and Would Require the Court to Overturn its Decision in *Morton v. Ruiz*.

The present case involves a fact situation virtually identical to *Ruiz* wherein the aggrieved Indians challenged the denial of Snyder Act benefits (off-reservation Bureau of Indian Affairs general assistance payments). In *Ruiz* this Court specifically discussed the nature of the federal trust responsibility as it applies to Indian people rather than to Indian trust land. The Court first found that Congress' general directives in the Snyder Act (to spend appropriated money for "Indians throughout the United States . . . for relief of distress and conservation of health"[11]), together with the general, lump-sum appropriation language of the 1968 Department of Interior and Related Agencies Appropriation Act, were ample authority to require the Bureau of Indian Affairs to make off-reservation general assistance payments.[12] Clearly the

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[11] 42 Stat. 208, 25 U.S.C. § 13; *see* further discussion *infra*, at 22-24.

[12] The Court disregarded a contrary provision in the BIA's Indian Affairs Manual, limiting benefits to reservation residents, as well as Congress' failure to appropriate funds for

Court does *not* limit the trust responsibility to cases involving only trust lands, but rather extends the federal responsibility to the interests of individual Indians as well.

Despite the clear language of *Ruiz*, the government relies on *United States* v. *Cherokee Nation of Oklahoma*, 480 U.S. 700 (1987), for the proposition that the trust responsibility is implicated only where Indian property is at stake and that, as a result, the trust does not enter into this case because the funds at issue are "gratuitous appropriations, not trust funds belonging to the Indians." Government Brief at 13-14, 24-25, *citing Scholder* v. *United States*, 428 F.2d 1228, 1229 (9th Cir. 1970), *cert. denied*, 400 U.S. 942 (1970), and *Quick Bear* v. *Leupp*, 210 U.S. 50, 80-81 (1908).

Scholder and *Quick Bear* are easily distinguished from the present case. The Ninth Circuit in *Scholder* mentioned the *Quick Bear* phrase, "gratuitous appropriations of public money," in dicta discussing a Fifth Amendment "taking" claim where the Court had already found the challenged use of the federal appropriations (to the benefit of a non-Indian irrigator within an Indian irrigation project) was permitted by the Snyder Act.

The *Quick Bear*[13] "gratuitous appropriations" versus "tribal"/"treaty" money distinction has no significance in contemporary Indian education law[A] where *all* federal Indian education programs are funded from public money,[14] or Indian health programs, which are all similarly funded from general revenues of the federal government, under the authority of the Snyder Act or the

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off-reservation general assistance payments. *Ruiz*, *supra*, at 210-213.

[13] *Quick Bear* addressed the question of whether or not federal education appropriations could be used for public schools where appropriation acts prohibited payment for sectarian education from "tribal" or "treaty" funds.

[14] E.g., Johnson O'Malley (JOM) Act, 25 U.S.C. §§ 452-454.

Indian Health Care Improvement Act.[15] The fact of general funding does *not* mean that Indian people have no right to challenge the termination, denial, or misuse of federal program benefits.[16]

The government's argument is flawed in its reliance on a decision of this Court which is inapposite to this case. The Court's decision in the 1987 *Cherokee Nation* case only involves asserted Indian property interests – in that case an interest in the mineral estate under a portion of the Arkansas River – so that the Court did not have before it a fact situation involving congressional appropriations, as it does here. *Cherokee Nation* does not support the argument that the trust responsibility applies only to Indian lands.

Indeed, quite the contrary is true. While many if not most of the Supreme Court decisions on the trust relationship may have involved Indian property, these decisions by no means limit the imposition or enforceability of the trust to property matters. In fact the dispute in *Morton v. Ruiz*, *supra*, involved Snyder Act appropriations – not property – which funded the Bureau of Indian Affairs' General Assistance program, and the issue of the scope of the agencies' distribution of those appropriated funds among the national Indian community. The Court in *Ruiz* never characterized those appropriations as "gratuitous;" indeed, it found that the Bureau was bound by a "distinctive obligation of trust" to "deal fairly with Indians" in the distribution of the funds.[17]

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[15] 25 U.S.C. 1601 *et seq.*

[16] *See*, e.g. Natonabah v. Board of Education of Gallup, McKinley County School District, 355 F.Supp. 716 (D.N.M. 1973) (challenging inappropriate use of JOM education funds by a school board), White v. Califano, 437 F.Supp. 543 (D.S.D. 1977), *aff'd* 581 F.2d 697 (10th Cir. 1978) (challenging denial of mental health services under the Snyder Act).

[17] *Ruiz*, *supra*, 415 U.S. at 236.

For this Court to agree with the government and limit the application of the United States' trust responsibility to matters involving property, it would be *required* to overturn the decision in *Ruiz* on this point, a result not even the government is seeking. *Amici* believe there is no principled way to distinguish *Ruiz* on the issue of whether the government bears a solemn trust responsibility to Indians in the administration of Indian health care programs funded by the Snyder Act, the Indian Health Care Improvement Act, and numerous congressional appropriation acts.

The government attempts to distinguish *Ruiz* on the basis that the Court there found a distinctive obligation to deal fairly with the Indians "only after the Court had concluded that Congress had made Indians living near reservations eligible for benefits," and as a result the duty of fairness was *triggered* by "the legitimate expectation of . . . [the] Indians." Government Brief at 41-42, quoting *Ruiz, supra,* 415 U.S. at 236. But this is a distinction without substance. If the test is, as the government asserts, whether the Indians' expectations of a trust duty in *Ruiz* are triggered by that one passage in the Snyder Act, that that test is met here, based on the entire body of federal legislative, judicial and administrative actions over the past two hundred years in matters involving Indian health.

The Court in *Ruiz* was also influenced substantially by the representations which the agency had made to Congress concerning the operation and administration of the general assistance program, as a means of justifying its budget request. These representations to Congress helped inform the Court on the agencies' interpretation and understanding of the trust duties it had accepted.[18] As in *Ruiz*, the Court here can apply the trust duty by deferring to representations made to Congress by the Indian Health Service and the Bureau of Indian Affairs

[18] *Ruiz, supra,* 415 U. S. at 214-228, 236.

concerning the success of the Indian Childrens Program and the importance of continued funding thereof.[19]

II. THE HISTORY OF DEALINGS BETWEEN THE UNITED STATES AND INDIAN PEOPLE EVINCES A SELF-IMPOSED OBLIGATION ON THE UNITED STATES TO PROVIDE HEALTH CARE TO INDIAN PEOPLE

To enable the Court to more fully understand why the government is bound in this case by this distinctive, *self-imposed* obligation, *amici* believe it is vital to trace the factual history of the United States' provision of health care to Indians and, importantly, the impact of the trends in general federal Indian policy which in many respects are directly responsible for the status of Indian health today.[20]

[19] Lower courts examining similar issues have found the trust obligation to extend to the government's delivery of health care to Indian people, in part on the basis of history, but also on the acknowledgement of the obligation as a matter of federal law and policy. McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987); White v. Califano, *supra*; Blue Legs v. Bureau of Indian Affairs, 867 F.2d 1094 (8th Cir. 1989). For a discussion of the trust in other contexts *see* Vigil v. Andrus, 667 F.2d 931 (10th Cir. 1982); Nance v. Environmental Protection Agency, 645 F.2d 701 (9th Cir. 1981); Kenai Oil & Gas, Inc. v. Department of the Interior, 671 F.2d 383 (10th Cir. 1982); Covelo Indian Community v. Federal Energy Regulatory Commission, 895 F.2d 581 (9th Cir. 1990).

[20] *See also,* United States Congress, American Indian Policy Review Commission, Task Force Six: *Indian Health, Final Report to the American Indian Policy Review Commission* (Washington, D.C. United States Government Printing Office 1976)(hereafter AIPRC Report); United States Congress, Office of Technology Assessment, *Indian Health Care,* OTA-H-290 (Washington, D.C. United States Government Printing Office 1986).

A. The Early Historical Period Between the United States and Indians is Marked by the Catastrophic Decline in the Indian Population Due to the Infestation of European Diseases and the Rapid Loss of Land Base and Access to Traditional Food Sources, and the Consequent Expansion of Federal Health Care Services to Indian People.

1. Colonial Period to 1832: The United States Began Providing Health Care to Indian People Soon After Diseases Carried by the Europeans first Devastated the Indian Population.

It is popular belief that few government services in the area of health were provided to Indians in the 19th Century, that few tribes received these services, and only then on the basis of sporadic agreements made in treaties with the United States.[21] Similarly, many inaccurately believe that Congress' involvement in Indian health care delivery did not commence until the enactment in 1921 of the Snyder Act.[22]

One popular misconception is that the Indian nations of the western hemisphere were "conquered" by dominant European governments.[23] Wars of military conquest indeed played a minor role in the settlement of the United States. However, the majority of Indian people were most commonly "conquered" by European diseases which, even if unintentionally spread,[24] were nonetheless

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[21] AIPRC Report, *supra*, note 20, at 27-32.

[22] 25 U.S.C. 13.

[23] See, e.g., Johnson v. M'Intosh, 21 U.S. (8 Wheat.) 543, 587-591 (1823).

[24] There are at least two documented instances in which Indian tribes were deliberately infected with smallpox by Europeans. The best known case was perpetrated by General Jeffrey Amherst during Pontiac's Rebellion in 1763. See Duffy, John, *The Healers: The Rise of the Medical Establishment*, at 6. In the Seventeenth Century, the Chippewa Tribe was deliberately infected with smallpox by representatives of a fur trading company in retaliation for having killed a white man. Schoolcraft, Henry R., *Narrative of an Expedition through the Upper Mississippi to Itasca Lake in 1832*, (New York, Harper Brothers, 1834) at 254-255.

deadly.[25] Malaria, typhoid, typhus, smallpox, cholera, measles, scarlet fever, diphtheria, and a host of other diseases did not exist on this continent before the arrival of European explorers. The indigenous populations of North America were entirely vulnerable to, and defenseless against, the ravages which followed contact with Europeans.[26]

It is believed today that prior to contact the Native population was at least 10 million people; by 1887 that number had been reduced to 250,000. Most scholars attribute this decline, referred to in the literature as "depopulation," primarily to European disease.[27] In the ensuing social and political disintegration and disarray it was relatively easy for the European explorers and settlers to establish themselves as "conquerors."[28]

In the history of the legal relationship between the United States and Indian tribes there has been a tendency

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[25] See Dobyns, Henry F., *Native American Historical Demography: A Critical Bibliography* (1976).

[26] For an explanation of how biological immunities occur and how they affect the course of a disease among a given population, see Cartwright, Frederick F., in collaboration with Michael D. Biddiss, *Disease and History*, at 54-81.

[27] See Dobyns, *supra*, at n.8; Stern and Stern, *The Effect of Smallpox on the Destiny of the American Indian* (1945).

[28] Stern and Stern, *supra*, at n.8.

to focus on laws asserting control over trade and land transactions.[29] This emphasis has often obscured the history of the relationship between early colonial, continental and state governments and Indian people in such matters as health and education. Nonetheless, the early history forms an important backdrop against which the contemporary federal obligation must be measured.

2. The Federal Responsibility for Indian Health Care was Expanded Through the Legislative Process.

The Continental Congress appropriated money for education as early as 1775.[30] In 1819 the United States Congress passed the Civilization Act which established a permanent annual appropriation of $10,000 to be distributed by the President to charitable groups, usually missionary societies, to finance Indian education.[31] Significantly, a portion of these appropriations were set aside for health care for the Indian students.[32] Colonial governments such as those in Massachusetts organized tribes into "praying towns" subject to considerable colonial control. "Guardians," who were appointed to oversee these praying towns, were given authority in many areas

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[29] *See* Trade and Intercourse Act of 1793 (Nonintercourse Act) 1 Stat. 329 (1793); County of Oneida, New York v. Oneida Indian Nation of New York State, 470 U.S. 226 (1985); 25 U.S.C. 261, 262 (federal licensing of traders on Indian reservations).

[30] Cohen, Felix, *Handbook of Federal Indian Law* (New Mexico University Press 1st ed. 1942) at 47, 238-244.

[31] Act of March 3, 1819, 3 Stat. 516.; *repealed*, Act of February 14, 1873, 17 Stat. 437, 461.

[32] U.S. Serials, Vol. 423, House Document No. 203, House of Representatives, 27th Congress, 3rd Session, "Amount Disbursed for Civilization of the Indians 1819 to 1842," dated March 2, 1843 (e.g. pp. 21, 22, 23, 25, 27); Cohen, note 30, *supra*, at 243.

of personal life, including the power to support those who were sick or otherwise unable to work.[33]

Other medical services such as vaccinations were provided to Indian people for many years, beginning in 1802, through military doctors.[34] In 1832, Congress appropriated funds to be used to vaccinate Indian people against smallpox and authorized the use of both military and private doctors to administer the vaccinations.[35]

In 1831 when Chief Justice John Marshall characterized the federal-Indian relationship as "resembling that of a ward to his guardian,"[36] the statement was not a summation of what the relationship ought to be, but rather a legal analogy describing the situation *which actually existed*. By the early 1830's the federal government had become the exclusive health care provider for Indian people although the services were limited and by no means adequate to fill the vast needs of the tribes. But for the efforts of the United States government, however, Indian people would have had very limited access to

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[33] *Laws of the Colonial and State Governments Relating to Indians and Indian Affairs from 1633 to 1831, Inclusive, Containing the Proceedings of the Congress of the Confederation and the Laws of Congress from 1800 to 1830 on the Same Subject*, Washington, D.C. Thompson and Homans, 1832 at 15 (1758 law).

[34] The administration of Indian affairs was under the jurisdiction of the War Department until 1849. Act of March 3, 1849, 9 Stat. 395; Cohen, note 30, *supra*, at 10-11; *A Study of the Indian Health Service and Tribal Involvement in Health*, Hearings before the Permanent Subcommittee on Investigations of the Committee on Government Operations of the United States Senate, 93rd Cong., 2d Sess., U.S. Government Printing Office, Washington, D.C. (Sept. 16, 1974) at 2.

[35] Act of May 5, 1832, 4 Stat. 514.

[36] Cherokee Nation v. Georgia, *supra*, 30 U.S. (5 Pet.) at 16-17.

western medicine and science.[37] Thus the obligation to provide health care to Indian people arose from the government's recognition of both its responsibility for the severe decline in Indian health and its duty to rectify it.

3. The Treaty Period, 1832 to 1871: Confinement of Indian People to Reservations During the Treaty Period of 1832 to 1871 Resulted in Stronger Federal Responsibility in Indian Health Programs Due to the Deterioration of Health Caused by the Inability to Gather Food, and the Restricted Access to Health Care.

The treaty period was defined by the United States government's desire to limit the territory used and occupied by Indian tribes, especially in the western United States. As settlers moved westward, competition between Indians and non-Indians for land, game and other natural resources increased, and conflict heightened. Through a combination of force and bargaining, the United States was able to negotiate 393 treaties during this period, resulting in a cession of 581,163,188 acres of land from the tribes to the United States.[38]

But the impact of the treaty and reservation process on the health of Indian people, and the corresponding shift in federal policy to address the serious needs created by this process, added greatly to the government's already distinct responsibility for Indian health care.

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[37] In later years the United States would actually outlaw the practice of traditional religions and medicine by Native Americans as a matter of law and policy. *See*, Fourth and Sixth Offenses, Regulations of the Indian Office, April 1, 1904 Secretary of the Interior (Washington: Government Printing Office, 1904) at pp. 102-03 [outlawing the "sun dance", "all other similar dances and so-called religious ceremonies" and the "usual practices of so-called medicine men"].

[38] Cohen, note 30, *supra* at 15, n. 115.

Through the process of establishing reservations Indian people were, in many instances, confined to reservations.[39] Those who attempted to leave reservations were often brutally forced back by the United States Army.[40] Prior to the reservation period, tribes had evolved economic systems which were closely related to the characteristics of the lands and natural resources within their aboriginal territories; e.g., in many instances there was great dependency on the proximity to available fish and game.

Confining a tribe on a much smaller parcel of land, even if the reservation lands were part of the much larger aboriginal holdings, often meant the disruption and destruction of the traditional means of subsistence. With traditional food supplies destroyed or inaccessible, many Indians were forced to depend on rations issued by the local Indian agent, which in many cases were insufficient or unsanitary.[41] Lack of traditional life practices contributed to declining individual fitness and health, and this deterioration was compounded by the deliberate suppression of tribal medicine practices.[42]

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[39] *See, e.g.*, Article II of the Treaty of October 14, 1865, with the Cheyennes and Arapahos, 14 Stat. 703, 704, which required the Indians to have the written consent of the Indian agent to leave their reservation. *See also*, the facts of the confinement of Geronimo's people, recounted in Fort Sill Apache Tribe of Oklahoma v. United States, 201 Ct. Cl. 630, 477 F.2d 1360 (1973), *cert. denied*, 416 U.S. 993 (1974).

[40] *See, e.g.*, Conners v. United States and the Cheyenne Indians, 33 Ct. Cl. 317 (1898), *aff'd.*, 180 U.S. 271 (1901).

[41] McGregor, Gordon, "Barriers to Economic Development," *American Indians, Facts and Future: Toward Economic Development for Native American Communities*, Report of the Joint Economic Committee, Congress of the United States (Arno Press, 1970) at 63.

[42] "American Indian Policy Review Commission's Report on Indian Health," *American Indian Journal*, Volume 3, Number 2 (February 1977) at 19.

Because confinement on a reservation left Indian people considerably more vulnerable to disease,[43] they became even more dependent upon the federal government for the provision of the necessities of life, including access to health care. Recognition of this dependency is mentioned in at least two dozen treaties which expressly obligate the United States to some form of health care for the Indian signatories thereto.[44] In all cases between the 1850's and 1910's the government filled the void in medical care for Indians through annual congressional appropriations for Indian vaccinations and other medical services, including the payment of physicians' salaries.[45]

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[43] *Tuberculosis Among the North American Indians: Report of a Committee of the National Tuberculosis Association Appointed on October 28, 1921*, Senate Committee Print, 67th Congress, 4th Sess., Printed for the Use of the Committee on Indian Affairs, Washington, D.C., Government Printing Office (1923) at 11.

[44] Cohen, note 30, *supra*, at 243 n. 86.

[45] Act of June 18, 1860, 12 Stat. 44, 57; Act of March 1, 1861, 12 Stat. 221, 237; Act of July 5, 1862, 12 Stat. 512, 528; Act of March 3, 1863, 12 Stat. 774, 790; Act of June 25, 1864, 13 Stat. 161, 179; Act of March 3, 1865, 13 Stat. 541, 558; Act of July 26, 1866, 14 Stat. 255, 278; Act of March 2, 1867, 14 Stat. 492, 514; Act of July 27, 1868, 15 Stat. 198; Act of April 10, 1869, 16 Stat. 13, 14; Act of July 15, 1870, 16 Stat. 335; Act of March 3, 1871, 16 Stat. 544, 545; Act of May 29, 1872, 17 Stat. 165, 166; Act of February 14, 1873, 17 Stat. 437, 440; Act of June 22, 1874, 18 Stat. 146, 148; Act of March 3, 1875, 18 Stat. 420, 423; Act of March 3, 1877, 19 Stat. 271, 272; Act of May 27, 1878, 20 Stat. 63, 66; Act of February 17, 1879, 20 Stat. 295, 297; Act of May 11, 1880, 21 Stat. 114, 116; Act of March 3, 1881, 21 Stat. 485, 501; Act of March 6, 1882, 22 Stat. 7, 9; Act of May 17, 1882, 22 Stat. 68, 86; Act of March 1, 1883, 22 Stat. 433, 449; Act of July 4, 1884, 23 Stat. 76, 94; Act of March 3, 1885, 23 Stat. 362, 380; Act of May 15, 1886, 24 Stat. 29, 43; Act of March 2, 1887, 24 Stat. 449, 464; Act of June 29, 1888, 25 Stat. 217, 233; Act of March 2, 1889, 25 Stat. 980, 997; Act of August 19, 1890, 26 Stat. 336, 355; Act of March 3, 1891, 26 Stat. 989, 1008; Act of July 13, 1892, 27 Stat. 120, 138; Act of March 3, 1893, 27 Stat. 612, 632; Act of August 14, 1894, 28 Stat. 286, 306; Act of March 2, 1895, 28 Stat. 876, 879; Act of June 10, 1896, 29 Stat. 324; Act of June 7, 1897, 30 Stat. 62, 65; Act of July 1, 1898, 30 Stat. 321, 571, 574; Act of March 1, 1899, 30 Stat. 924, 927; Act of May 31, 1900, 31 Stat. 221, 224, 241; Act of March 3, 1901, 31 Stat. 1058, 1061, 1071; Act of May 27, 1902, 32 Stat. 245, 248; Act of March 3, 1903, 32 Stat. 982, 985; Act of April 21, 1904, 33 Stat. 189, 192; Act of March 3, 1905, 33 Stat. 1048, 1050; Act of June 21, 1906, 34 Stat. 325, 330, 339; Act of March 1, 1907, 34 Stat. 1015, 1018, 1025; Act of April 30, 1908, 35 Stat. 70, 74; Act of March 3, 1909, 35 Stat. 781, 784; Act of April 4, 1910, 36 Stat. 269, 271.

Federal Indian agents also had discretionary authority to employ physicians for Indians living on reservations;[46] by 1874 about half of the sixty-nine Indian agencies had a doctor in residence.[47]

4. The Allotment Period, 1871 to 1921:[48] The Bureau of Indian Affairs Expanded the Number of Medical Personnel Serving Individual Indians, Who, Due to the Increased Breakdown of Tribal Connections Caused by Allotment Policies, Were Continuing to Experience Unmet Medical Needs.

Between 1874 and 1900, the number of doctors in residence on reservations had nearly tripled,[49] and by

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[46] United States v. Patrick, 73 F. 800, 20 C.C.A. 11 (C.C.A. 8, 1896), *error dismissed*, 18 S.Ct. 949, 42 L.Ed. 1216 (1898).

[47] Cohen, note 30, *supra*, at 243. According to the Appropriations Act of June 22, 1874, 18 Stat. 146-147, there were sixty-nine Indian agencies in that year.

[48] Allotment refers to the General Allotment (Dawes) Act of 1887, Act of February 8, 1887, 24 Stat. 388, and the well known period wherein vast holdings of tribal, communal lands on Indian reservations were broken up and "allotted" to individual members of the tribe, to be held in trust by the government until such time as the individual was deemed capable of managing his or her own affairs. See, e.g., Cohen, note 30, *supra*, at Chapter 11.

[49] Act of March 1, 1899, 30 Stat. 924-926.

1912 the Bureau had 160 doctors in the field, two-thirds of whom were full-time Bureau employees.[50]

During the late nineteenth century, hospitals funded by the federal government became a part of the health care delivery system for Indian people. The first Indian service hospital was built in 1882, in conjunction with the Carlisle Indian Boarding School, the first off-reservation boarding school. By 1900, there were five Bureau of Indian Affairs' hospitals with a total capacity of 150 beds.[51] Congress appropriated funds for the construction of an insane asylum for Indian people at Canton, South Dakota in 1899,[52] and a tuberculosis sanitorium in 1906-1907.[53]

Despite these efforts, Indian health statistics still lagged significantly behind those of the American public at large. In 1912, for example, the death rate for Indian people was 35 per thousand, more than twice the national rate of 15 per thousand. Approximately 15% percent of the national Indian population was estimated to have trachoma and tuberculosis.[54] Citing these grim statistics,

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[50] Message of President Taft, 48 *Cong. Rec.* 10643 (August 10, 1912, Senate Doc. No. 907).

[51] Tyler, S. Lyman, *A History of Indian Policy*, United States Government Printing Office 1973, at 90; Raup, Ruth M., *The Indian Health Program from 1800 to 1955* at 3, 9 (unpublished paper available from the National Indian Law Library, Boulder, Colorado).

[52] Act of March 1, 1899, 30 Stat. 924.

[53] Act of June 21, 1906, 34 Stat. 325, 328; Act of March 1, 1907, 34 Stat. 1015, 1052.

[54] Message of President Taft, *supra*, at n.50.

President Taft, in his statement in support of congressional appropriations for Indian health, remarked that "[a]s guardians of the welfare of the Indians, it is our immediate duty to give the race a fair chance for an unmaimed birth, a healthy childhood, and a physically efficient maturity."[55]

Federal policies regarding Indian health during the allotment era followed the general shift toward assimilation and focused on the health care needs of *individual* Indian people. The shift in philosophy was characterized in federal policy by the elevation of the individual Indian above the tribal community, fostering individual initiative, education and Christianization. The real *objects* of the guardianship relationship became Indian people rather than the tribes. By weakening the identification between individual Indians and their tribal communities, allotment policies further strengthened the dependence of individual Indians on the federal government. Indeed, the Supreme Court justified the policies and process of allotment on the ground that the federal government was obligated to step in and protect individual Indians because living in tribal communities had not resulted in individual prosperity in the western sense of the term.[56]

The impact of the allotment era on the federal bureaucracy was immediate and significant. The Bureau of Indian Affairs was given the responsibility within the federal bureaucracy of transforming Indian people into self-supporting, productive American farmers and citizens. At a minimum, this meant educating and improving the health of Indian people so that they could fulfill the expectations of federal policy. The Bureau, which had once only been concerned with the activities of a few hundred tribes and reservations, was suddenly forced to

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[55] *Id.*

[56] Cherokee Nation v. Hitchcock, 187 U.S. 294, 301-302 (1902), *quoting in part* Stephens v. Cherokee Nation, 174 U.S. 445, 450 (1899).

establish and institutionalize programs to serve several hundred thousand individual Indians. The result was an unprecedented era of growth; from 1887 to 1920 the Bureau's budget tripled, the bureaucracy flourished, and along with it, medical services continued to expand.

B. The Modern Era Evinces a Continuing, and Expanding Self-Imposed Trust Obligation on the United States to Provide Health Care to Indian People.

The modern era is characterized primarily by two factors: significantly increased congressional appropriations and, for the first time, comprehensive federal legislation to deal comprehensively with Indian health care issues. This legislation has continued to acknowledge the United States' obligation to meet the health care needs of Indian people.

1. The Snyder Act and the Indian Reorganization Act.

a. The Snyder Act of 1921[57] provided for the first time a permanent legislative authorization for congressional appropriations in the area of Indian health care.

> [T]he Bureau of Indian Affairs [shall] . . . direct, supervise, and expends such monies as Congress may from time to time appropriate, for benefit, care, and assistance of the Indians throughout the United States. . . . For the relief of distress and conservation of health . . . and [f]or the employment of . . . physicians. . . . [58]

There were procedural reasons for enacting a statute which authorized the expenditure of federal funds to

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[57] Act of November 2, 1921, 42 Stat. 208, 25 U.S.C. 13.

[58] *Id.*

meet the government's duty to provide for Indian health care services.[59] Shortly before the passage of the act, jurisdiction over appropriations for Indian affairs in the House of Representatives had been transferred from the Indian Affairs Committee to the Appropriations Committee.[60] This move sparked a jurisdictional dispute between the committees, during which the members of the Indian Affairs Committee expressed their displeasure with the new state of affairs by a spate of point of order objections.[61] The Act was passed in part then as a reaction to this procedural deadlock.

But of equal importance in the history of the enactment of the Snyder Act, and what is missing from the government's present characterization of the Act's purpose, is Congress' recognition of the preexisting *and* continuing duty to provide Indians with health care.[62] Government's Brief at 16-18. Most importantly the debate on the Act demonstrates that Congress authorized Snyder Act services to *continue* its obligations under the federal trust responsibility.

Members of the House of Representatives debating the Snyder Act were well aware of the guardianship responsibility of the United States with respect to Indian affairs,[63] of the poor health status of Indian people,[64] and

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[59] H.R. Rep. No. 275, 67th Cong., 1st Sess. (1921); S. Rep. No. 294, 67th Cong., 1st Sess. (1921).

[60] 61 *Cong. Rec.* at 4671-4672 (August 4, 1921).

[61] *Id.* at 4671-4673.

[62] Programs providing Indian health services had been viewed for years as " . . . integral parts of the Indian service, nearly all of which had been appropriated from year to year, and which will continue, in all probability, as long as the service does." H.R. Rep. No. 275, 67th Cong., 1st Sess. (1921), and 61 *Cong. Rec.* at 4684.

[63] *Id.* at 4660, 4681, 4686.

[64] *Id.* at 4663.

of the importance of health care to the future productivity and well-being of Indian people.[65] Indeed, during the debate Representative Leatherwood of Utah went so far as to characterize health care as one of the "fundamental" obligations of the United States to Indian people.[66]

b. The Indian Reorganization Act, which was passed as an attempt to strengthen Indian tribal institutions, also contained an increase of federally provided health services.

In 1934 Congress passed the Indian Reorganization Act (IRA),[67] expressly as a repudiation of the failed policies of allotment and assimilation.[68] The IRA was part of the genesis of new federal policies aimed at Indian country, commonly known as the "Indian New Deal."[69] Continuing a trend established in previous historical periods, the United States' commitment to Indian health care was further strengthen by the IRA. By 1940 the federal government was spending over $5 million annually to provide medical services to Indian people.[70] These increased appropriations were coupled with an interagency agreement which allowed the BIA to use Public Health Service doctors on Indian reservations. By 1940 the BIA employed 200 doctors and 600 graduate nurses working

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[65] *Id.* at 4664.

[66] *Id.* at 4677.

[67] Act of June 18, 1934, 48 Stat. 984, 25 U.S.C. 461 *et seq.*

[68] The 1928 *Meriam Report* ("The Problem of Indian Administration"), published by the Brookings Institution, denounced the results of fifty years of allotment policy and of federal efforts to force Indian people into the American mainstream to compete for jobs.

[69] Cohen, note 1, *supra*, at 147-151.

[70] Cohen, note 30, *supra*, at 243 n. 94.

in hospitals that had a system-wide direct care capacity of over 4,000 beds.[71]

2. The Johnson O'Malley Act (JOM), Passed in 1934,[72] Acknowledged the United States' Responsibility to Provide Comprehensive[73] Medical Services for Indian People.

The Johnson O'Malley Act authorized the Secretary of the Interior to enter into contracts with state and local governments to provide for the "education, medical attention, agricultural assistance and social welfare" Indian people in instances where, as a result of allotment, tribal life was broken up and many Indian people were no longer on reservations.[74] The federal government via JOM would remain financially responsible for services to individual Indians.[75]

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[71] Raup, note 51, *supra*, at 9-12.

[72] Act of April 16, 1934, 48 Stat. 596, amended by the Act of June 4, 1936, 49 Stat. 1458, 25 U.S.C. 452 *et seq.*

[73] There is little doubt that the intent was to obligate the federal government to provide comprehensive medical services to Indians: "medical attention" in the act is defined to include " . . . physical examinations, medical and surgical work and treatments, hospitalization, dispensary and convalescent care, nursing, sanitation and the application of such other public health measures as might be necessary, including the prevention, investigation, suppression and control of contagious and communicable diseases." S. Rep. No. 511, 73 Cong., 2d Sess. at 3-4 (1934); H.R. Rep. No. 864, 73 Cong., 2d Sess. at 3 (1934).

[74] S. Rep. No. 511, 73rd Cong., 2d Sess. at 1-2 (1934).

[75] *Id.* at 3; H.R. Rep. No. 864, 73 Cong., 2d Sess., at 2 (1934).

3. The Transfer Act Further Strengthened Government Commitment to Provide Health Care for Indians Even During the Termination Era When the Government Questioned its Relationship with Indian Tribes.

Passed in 1954 at the height of the Termination Era in Indian policy,[76] the Transfer Act[77] transferred "all functions, responsibilities, authorities and duties of the Department of the Interior, the Bureau of Indian Affairs, the Secretary of the Interior and Commissioner of Indian Affairs relating to the maintenance and operation of hospital and health facilities for Indians . . . " to the newly created Indian Health Service of the Department of Health Education and Welfare (now Department of Health and Human Services).[78]

By its terms the Transfer Act implicitly acknowledged the obligation of the United States to provide health care to Indian people.[79]

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[76] The Termination Era describes the period of time between 1943 and 1961 in which the United States Congress unilaterally revoked the "recognized" political status of dozens of Indian tribes. For an in depth discussion of termination, see Cohen, note 1, *supra*, at 152-180.

[77] Act of August 5, 1954, 68 Stat. 674, amended by Section 69(a) of the Health Maintenance Organization Act of 1973, 87 Stat. 935, 42 U.S.C. 2001 *et seq*.

[78] 68 Stat. 674.

[79] Also enacted in the termination era were the Indian Health Facilities Act of 1957, Pub. L. 85-151, 42 U.S.C. 2005 (authorized the Indian Health Service to contribute to the construction costs of community hospitals), and the Indian Sanitation Facilities and Services Act of 1959, Pub. L. 86-121, 42 U.S.C. 2004 (authorized IHS to provide sanitation facilities to Indian people, including domestic and community water supplies and facilities, drainage facilities, and waste disposal facilities for Indian homes, communities, and lands).

The act is noteworthy since the acknowledgement of continuing federal responsibility came at a time when the prevailing mood was to eliminate tribalism in the United States. The message was clear, the obligation to provide health care for individual Indians would not be shirked. The Senate report on the proposed transfer acknowledged that "the Bureau of Indian Affairs is responsible, under present law, for the *total health program* – both preventive and curative medicine – for all Indians registered as members of the various tribes in the United States and Indians and natives in Alaska."[80] Indeed, the legislative history of the Act shows that the transfer was motivated in large part by the desire to *improve* the quality of medical services provided to Indian people by placing the administration of their health program under the professionally administered and better funded Public Health Service.[81]

4. The Indian Health Care Improvement Act, Passed When the United States Had Returned to a Policy of Strengthening Indian Tribes, Continued the Government's Commitment to Health Care for Indian People.

The first significant piece of Indian health care legislation in the modern Self-Determination Era[82] is the

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[80] S. Rep. No. 1530, 83rd Cong., 2d Sess., (1954), as reprinted in the U.S. Code Cong. and Admin. News, 83rd Cong., 2d Sess. (1954) Volume 2 at 2918-2919 (emphasis added).

[81] *Id.* at 2926-2927, 100 *Cong. Rec.* 8959, 8960, 8963-8966. It was the prevailing sentiment in the Congress that "the Indian shall have a health service and hospital service comparable to that which the white man receives." Remarks of Senator Thye of Minnesota, 100 *Cong. Rec.* 8962 (June 25, 1954).

[82] Generally considered to be from 1961 to the present date. *See* Cohen, note 1, *supra*, at 180-206.

Indian Health Care Improvement Act of 1976 (IHCIA).[83] The congressional findings in the introduction of the legislation reflect the almost two hundred year history of the federal government's primary role as provider of Indian health care services. These findings concisely state the continuing problems and the continuing commitment of the United States government to address them:

> (a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with and resulting responsibility to the American Indian people.
>
> (b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
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> • • •
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> (e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of American Indian people.[84]

To fulfill the United States' obligation the IHCIA established a variety of programs designed to improve the scope and quality of federal health services, including the elimination of backlogs of known unmet needs, the upgrading of inadequate facilities, and of urban and rural

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[83] Act of September 30, 1976, 90 Stat. 1400, 25 U.S.C. 1601 *et seq.*

[84] 25 U.S.C. 1601(a), (b), and (e).

Indian health services.[85] Subsequent amendments continue to improve and expand substantially the quality and scope of Indian health programs.[86]

C. Summary.

In summary, the history of the dealings between the United States and Indian people in matters involving Indian health discussed in the preceding section shows clearly the depth of the federal government's commitment to a trust responsibility. In passing the Snyder Act, Congress created authorizing legislation for health programs which had been evolving over the years as part of the federal-Indian trust relationship. Any perceived ambiguities in the Snyder Act were clarified by subsequent legislation. The legislative history of the Johnson O'Malley Act shows that Congress intended to provide comprehensive medical services to all members of federally recognized tribes, even though many Indians were no longer isolated geographically from the general population.

That Congress continually reaffirmed the importance of providing medical care to all tribal members can be seen in the Transfer Act, passed in order to improve the quality of medical services to Indians even in the height of the termination era. In 1976 Congress passed the Indian Health Care Improvement Act to make an unequivocal statement that the government's Indian health care delivery system was "consonant with and

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[85] *See, e.g.*, Titles II, III, and V of the IHCIA, 25 U.S.C. 1621, 1631, and 1651.

[86] *See, e.g.*, Pub. L. 100-713, Nov. 23, 1988, 102 Stat. 4784; Pub. L. 102-573, October 29, 1992, 106 Stat. 4526.

required by the unique legal relationship between the federal government and Indian people.[87]

From this almost two century history Indian people have a well deserved expectation to be treated fairly by federal agencies in the delivery of health care services. It derives from the trust responsibility, which the United States has a legal and moral obligation to uphold. The federal courts deciding this case below understood this obligation in ruling for the Respondent Indian children.

CONCLUSION

For the foregoing reasons the decision of the Tenth Circuit Court of Appeals should be affirmed.

Respectfully submitted,

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[87] 25 U.S.C. 1601(a).